STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005106	A. BUILDING: _____ B. WING _____	02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL	901 MACARTHUR BLVD MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was for investigation of a State complaint. Complaint: #IN00127295 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005106 Survey Date: 02/25/2014 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Community Hospital is in compliance with 410 IAC 15-1.5-5, Physician Services, 410 IAC 15-1.5-7, Pharmaceutical Services, and 410 IAC 15-1.6-8, Surgical Services, Hospital Licensure Rules. QA: claughlin 02/28/14	S 000		